DeltaCare® USA

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Check One **Broker #: _2014279____**

- ❑ New Enrollment
- ❑ Name Change

Indicate effective date of change:
*(Does not pertain to facility change)

Month ____ Day ____ Year ____

DeltaCare USA SENIOR PROGRAM
ENROLLMENT AND PAYMENT AUTHORIZATION FORM

Applicant Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY - (PLEASE LEAVE ONE BLANK BOX BETWEEN EACH WORD)

Name: _____ (Last) _____ (First) _____ (MI)

Mailing Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zip Code)

Date of Birth: ____ (Month) ____ (Day) ____ (Year)

Male ❑ Female ❑

Home Phone #: (____) ____ — ____

Identification #: ____ — ____ — ____

Contract Facility Name: _____

Contract Facility #: _____

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that Delta Dentalís ratio of health care expense to premiums received for the last calendar year, with respect to the DeltaCare USA Individual/Family Dental Program, was 67.38%.

Return form to Delta Dental of California at P.O. Box 660138, Dallas, TX 75266-0138

_____ Signature of Applicant:

_____ Date:

PLEASE PRINT LEGIBLY

Please complete both forms

PROGRAM COST

Choose one based on the information on the reverse side.

Enrollee Premium	**$ 135.00**
One-time Enrollment Fee	**$ 15.00**
TOTAL	**$ 150.00**

This Enrollment and Payment Authorization Form and your check or money order, if applicable, must be received by the 21st day of the month for your coverage to be effective on the first day of the following month.

I wish to enroll in the DeltaCare USA Senior Dental HMO Program. I acknowledge that I have read the Disclosure Form/Contract and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of Delta Dental, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Delta Dental provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

PAYMENT OPTION (choose only one)

PAYMENT OPTIONS

❑ CHECK/MONEY ORDER PAYMENT OPTION

Please make check or money order payable to Delta Dental of California.

You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of coverage.

❑ CREDIT CARD PAYMENT OPTION

❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS

CARD # _____

EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CARD

_____

SIGNATURE _____

DATE _____

By signing above you authorize Delta Dental of California to charge your credit card account for the cost of the DeltaCare USA Program.

Note: Any credit card refunds under the Program may be made by check or credit card.

Signature: _____ Date: _____

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